FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

August 5, 2016

The Honorable Sylvia Mathews Burwell
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Ohio's 1115 Medicaid expansion waiver request, Healthy Ohio Program

Dear Secretary Burwell,

Thank you for the opportunity to comment on the Healthy Ohio 1115 demonstration request.

Families USA is a national organization representing the interests of health care consumers, with a particular focus on low-income consumers. We are very supportive of Ohio's Medicaid expansion, which has enabled more than 600,000 Ohioans to gain access to health coverage. Early evidence indicates that expansion enrollees are using their coverage efficiently and accessing more preventive health services.[1]

Many of the changes proposed in the Healthy Ohio waiver would set back the state's progress by making it more difficult for Medicaid eligible individuals to get and keep coverage. They are incompatible with the goals and objectives of the Medicaid program, serve no demonstration purpose, and should not be approved.

Comments on specific provisions are as follows:

Charging enforceable premiums to enrollees at all income levels is incompatible with the goals of the Medicaid program, serves no demonstration purpose, and should not be approved.

[1] Tony Gutowski, "How Expanded Medicaid is Already Helping," The City Club of Cleveland Blog Post, February 18, 2016 online at https://www.cityclub.org/blogs/how-expanded-medicaid-is-already-helping.

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Monthly Buckeye account payments are functionally premiums and CMS should evaluate them as such.

In its waiver application, the state asserts that the required monthly Buckeye account payments are not premiums because enrollees can take account balances with them when they leave the program. However, the effect of these payments on coverage and access to health services is equivalent to a premium and therefore should be evaluated as such. The proposed program requires:

- Payments of the lesser of 2 percent of income or $99/year from all non-disabled enrollees 18 to 64, except pregnant women and enrollees with no income;
- An initial payment before coverage begins;
- Continued timely payments for continued coverage, with coverage terminated if payments become 60 days or more past due; and,
- Payment of back-due amounts for coverage reinstatement.

Regardless of whether account balances can be moved or not, for purposes of individuals getting and keeping coverage, the Buckeye account payments are premiums.

The imposition of premiums serves no demonstration purpose and is not in keeping with the goals of the Medicaid program.

As we have noted in our comments on 1115 expansion waiver proposals from Arizona[2], Arkansas[3], Indiana[4], Iowa[5], Michigan[6], Montana[7], and Pennsylvania[8], premiums in Medicaid do not serve a demonstration purpose. The impact of premiums on low-income people is well documented and is in conflict with the goals of the Medicaid program. Adding premiums, particularly with a disenrollment penalty, would reduce

[2] Families USA Comments on Section 1115 Waiver related to Arizona AHCCCS Care Program (December 4, 2015) http://familiesusa.org/sites/default/files/documents/AZ%20comments%20FUSA_FINAL.pdf

[3] Families USA Comments on Section 1115 Waiver related to Arkansas Health Care Independence Program (Sept. 7, 2013) http://familiesusa.org/sites/default/files/documents/Families%20USA%20AR%201115%20Comments%209-7-13.pdf

[4] Families USA Indiana Section 1115 Waiver HIP 2.0 Program (September 19, 2014) http://familiesusa.org/sites/default/files/documents/Families%20USA%20Comments%20HIP%202%200%201115%20waiver.pdf

[5] Families USA Comments on Section 1115 Waiver related to Iowa Health and Wellness and Iowa Marketplace Choice Plans (Sept. 26,2013) http://familiesusa.org/sites/default/files/documents/Families%20USA%20Iowa%201115%20Comments%209-26-13.pdf

[6] Families USA comments on Michigan Section 1115 Waiver Healthy Michigan Program (December 18, 2013) http://familiesusa.org/sites/default/files/documents/Families%20USA%20comments%20Michigan%201115%20Adult%20Benefit%20Waiver%20amendment.pdf

[7] Families USA comments on Montana Section 1115 HELP waiver request, filed with CMS on October 15, 2015.

[8] Families USA comments on Pennsylvania Section 1115 Healthy Pennsylvania Program (April 10, 2014) http://familiesusa.org/sites/default/files/documents/Families%20USA%20Comments%20Healthy%20Pennsylvania%201115%20waiver%20request.pdf

coverage and, as a consequence, have a negative impact on health outcomes for Medicaid eligible Ohioans subject to such payments. In Ohio, the state estimates that enrollment under Healthy Ohio will be *9 percent lower* than if its Medicaid program continues as is.[9] That is in direct conflict with the criteria CMS asserts that it uses to evaluate demonstration waiver requests.[10]

Even assuming there is a hypothesis to be tested and a demonstration purpose behind assessing premiums on Medicaid enrollees, this hypothesis is already being tested in several states. In fact, preliminary evidence from premium programs approved in Medicaid expansions supports earlier studies that show that premiums in Medicaid pose a financial hardship on enrollees.[11] Until further evaluation of premiums in existing demonstrations, including an independent evaluation of Indiana's HIP 2.0 waiver, CMS should not approve premiums in additional Medicaid or Medicaid expansion programs.

If CMS does approve premiums for Ohio's program, it should require significant modifications to the requested program.

We strongly disagree with the imposition of premiums and associated non-payment penalties in Medicaid. However, should CMS approve Ohio's request to add premiums to its program, it should require extensive modifications to the waiver request.

- ***Non-expansion enrollees and the medically frail should be excluded from any premium program approved.***

Ohio is requesting to apply its premium program to all adults in Medicaid who are not pregnant or disabled, regardless of their income. That would include adults covered by the state's traditional Medicaid program as well as medically frail expansion enrollees. Any premium program approved should exclude pregnant women, non-expansion adults, people with disabilities, and expansion enrollees who are medically frail. These groups may have high medical needs and should be exempted from the barriers to coverage that premiums inevitably create.

[9] Ohio Department of Medicaid, "Healthy Ohio Section 1115 Demonstration Waiver Summary," April 2016, http://medicaid.ohio.gov/Portals/0/Resources/PublicNotices/HealthyOhio-Summary.pdf.

[10] Among criteria CMS uses to evaluate 1115 waivers, the first listed is whether the demonstration will increase and strengthen coverage of low-income residents in the state. https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html

[11] Andrea Callow, "Charging Medicaid Premiums Hurts Patients and State Budgets," Families USA Blog, April 2016 http://familiesusa.org/product/charging-medicaid-premiums-hurts-patients-and-state-budgets.

- ***CMS should not approve enforceable premiums for enrollees with incomes below poverty.***

We do not believe that disenrollment penalties have a place in the Medicaid program. However, should CMS allow enforceable premiums in Ohio, they should not apply to enrollees with incomes below poverty.

CMS has not approved a premium structure that includes loss of coverage as a non-payment penalty for enrollees with incomes below poverty in any Medicaid expansion waiver request. In Montana and Iowa, where premiums begin at fifty percent of poverty, enrollees below poverty who miss premium payments accumulate a debt to the state, but their coverage continues. In Indiana, enrollees below poverty who do not make premium payments are moved to a program with fewer benefits, but they retain coverage.

A disenrollment penalty for enrollees below poverty would cause many to lose coverage. Ohio is requesting to further compound that hardship by locking individuals out of coverage until they pay back any owed premiums. For many of the poorest Medicaid eligible individuals in the state, the combined premiums and back-payment provisions would make coverage effectively inaccessible. The proposed program serves no demonstration purpose and is in stark conflict with Medicaid's objective of providing affordable health coverage to low-income individuals. (See our recommendations regarding coverage lockouts, below.)

- ***If premiums are approved below poverty, the amount should be less than 2 percent of income.***

Ohio proposes 2 percent premiums at all income levels. If CMS does approve premiums below poverty, the amount approved should be less than the proposed 2 percent of income.

In the marketplace, the availability of tax credits and the percent of income that an individual is expected to contribute to premium payments changes as an individual's income changes. One can assume that if tax credits were available to individuals below poverty, the percent of income those individuals would be required to pay towards premiums would be less than 2 percent, with the percent continuing to decline as income declines. That same logic should apply to any premiums allowed in Medicaid expansion programs. For enrollees below poverty, any premiums allowed should be less than 2 percent of income.

- ***CMS should not approve any premiums for enrollees below 50 percent of poverty.***

If CMS does approve premiums for Ohio's program, they should be limited to enrollees with incomes above 50 percent of poverty. As recently as one year ago, ASPE issued a report on the effect of cost-sharing and premiums on individuals in deep poverty, defined as below 50 percent of poverty. That report stated:

> When subject to copayments and premiums, low-income individuals must decide whether to go to the doctor, fulfill prescriptions, or pay for other basic needs like child care and transportation. As a result of these daily tradeoffs, low-income individuals are especially sensitive to modest and even nominal increases in medical out-of-pocket costs.[12]

CMS has not approved premium payments for enrollees below 50 percent of poverty in any Medicaid expansion except Indiana's and should not do so in Ohio. Indiana's program, which requires enrollees below poverty to pay premiums to remain in a higher benefit program, was based on an existing demonstration in the state. That is not the case in Ohio. Furthermore, as noted above, in Indiana, enrollees below poverty are moved to a lesser benefit program if they fail to pay premiums. They do not lose coverage.

- ***CMS should not approve coverage lock-outs at any income level.***

Locking individuals out of coverage is antithetical to Medicaid's goals and CMS should not approve them at any income level. CMS should stand by its comments in a recent letter to Indiana regarding the state's request to add lock-outs for individuals who do complete a redetermination process. In that letter, it was noted, "Exclusions from coverage, such as lockouts, are not permitted under Medicaid law."[13] CMS is correct in that interpretation and should not allow coverage lock-outs in Ohio.

- ***Coverage should begin upon an eligibility determination, not premium payment.***

Delaying coverage until the first premium payment, particularly for those below poverty, will essentially put coverage out of reach for many. CMS has not approved any comparable coverage delays and should not approve Ohio's request.

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[12] Office of the Assistant Secretary for Planning and Evaluation, "Financial Condition and Health Care Burdens of People in Deep Poverty," July 16, 2015, http://aspe.hhs.gov/basic-report/financial-condition-and-health-care-burdens-people-deep-poverty

[13] July 29, 2016 letter from Vikki Wachino, Center for Medicare and Medicaid Services, to Tyler Ann McGuffee, Insurance and Healthcare Policy Director, Office of Governor Michael Pence, Indiana.

The closest approval was for Indiana, where CMS has allowed coverage to be withheld for up to 60-days for enrollees below poverty, pending a first premium payment. However, after 60-days, individuals who have not paid premiums receive coverage in a lesser benefit program.

While we do not believe that delaying coverage or effective waiting periods, such as that approved in Indiana, are appropriate in Medicaid, they are particularly inappropriate for enrollees with incomes below poverty.

- ***CMS should not approve imposition of copayments in conjunction with premiums, particularly not for the lowest income enrollees.***

Ohio proposes to impose both premiums and copayments on all enrollees, compounding the financial strain of premiums. Ohio should not be allowed to charge both premiums and cost sharing, particularly for enrollees below poverty. If CMS is inclined to approve both premiums and copayments, we urge that, at the least, they take the approach used in Montana and apply premiums payments to copayments owed.

The Buckeye account structure is confusing and unlikely to improve care.

The proposed Buckeye account is confusing and unlikely to promote better health care use. The account is based on Indiana's Power Account concept. Indiana's waiver evaluation report shows that few enrollees understand their Power Accounts; it does not support the contention that Power Accounts affect service use in any positive way.[14] The accounts add to enrollee confusion and administrative cost, with no discernable health care benefit. CMS should not approve additional account programs.

CMS should not approve the request to omit retroactive eligibility.

Retroactive eligibility is a fundamental part of the Medicaid program. Omitting this coverage from Ohio's program would make it more difficult for eligible individuals who are not yet enrolled to receive care and would place them at risk for medical debt if they are able to obtain care. It would also increase health care providers' risk for bad debt. We urge that this request be denied. However, at the least, if CMS were to consider this request, it should require the state to implement a presumptive eligibility system or other program to mitigate the risk to Medicaid eligible individuals and providers.

[14] The Lewin Group, "Indiana Healthy Indiana Plan 2.0: Interim Evaluation Report," July 6, 2016, http://www.in.gov/fssa/hip/files/Lewin_IN%20HIP%202%200%20Interim%20Evaluation%20Report_FINAL.pdf.

The annual and lifetime limits are confusing and there is insufficient detail to ensure continuity of care.

Ohio is proposing that the demonstration have a $300,000 annual and $1 million lifetime maximum. Once an individual has used that level of coverage, he or she would be transferred out of the demonstration to a Medicaid managed care plan or fee-for-service Medicaid.

Individuals using that volume of care will most likely have complex medical conditions and be treated by multiple providers. The waiver request provides little information on how transfers will be managed to ensure care continuity and reduce complications that can ensue when individuals with high medical needs move from one plan, and possibly one provider, to another. CMS should require more detail of this aspect of the program before approval.

Robust evaluation should be required for any program changes.

Any changes to Ohio's program should be subject to robust evaluation. Should premiums or other elements be added to the Ohio program, we urge CMS to ensure that there is a robust evaluation process in place. This process should track the full impact of program changes, comparing coverage retention and access to services both before and after the program change. We also recommend a shorter than standard approval time.

Conclusion

Ohio's Medicaid waiver proposal would make it more difficult for low-income, Medicaid eligible Ohioans to get and keep coverage. The state is asking CMS to approve a premium payment program that places a greater financial onus on the lowest income enrollees than any program CMS has approved to date.

With each approval of an 1115 expansion waiver that includes any features that can make it more difficult for enrollees to keep or afford coverage, like premiums, additional states have asked for the same. States, both that have and have not expanded Medicaid, are watching to see how restrictive CMS will allow Medicaid programs to become.

However, the fact is that 1115 waivers are demonstration programs. Approval of one demonstration should not guarantee approval of the next. Demonstration programs are not intended to be non-legislative mechanisms for remaking the Medicaid program. Approval of a program feature in one state should not guarantee the same in any other state.

This waiver is an opportunity for CMS to send a strong signal regarding what it will and will not approve related to Medicaid and Medicaid expansion programs, and to make clear that Medicaid must remain affordable and accessible to the individuals it covers. Thank you for your consideration of these comments. If you have any questions, please contact either Dee Mahan or Melissa Burroughs at (202) 628-3030.

Respectfully submitted,

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